OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
Healthcare Information Division - Healthcare Information Resource Center
400 R St, Room 250 ~ Sacramento, California 95811 Phone (916) 326-3800 FAX (916) 324-9242
www.oshpd.state.ca.gov/HID/HIRC

Application for SB 306 Extension / Delay in Compliance

A

Name of Facility:
E-mail:
Street Address:
Phone:
FAX#:
City: County: Zip:

OFFICE USE ONLY
OSHPD #:
Facility I.D. #:

Name of Facility Representative/Administrator:
E-mail:
Mailing Address:
Phone:
FAX#:
City: State: Zip:

Legal Owner: Phone:
Mailing Address:
City: State: Zip:

B

Application Submitted by:
Name:
Signature:
Title:
Address:
City: State: Zip:
Phone #: FAX #:
Who is to be known as: ❑ Legal Owner/Administrator
❑ Agent for the Legal Owner/Administrator **(Authorization must be attached)**

OSHPD RECEIPT STAMP

C

Fee Submittal:
Filing Fee……**$1,000.00**

Method of Payment:
❑ Send Invoice to: ❑ Administrator ❑ Legal Owner ❑ Agent for Legal Owner/Administrator
❑ Check – Made payable to OSHPD
❑ Visa ❑ Master Card ❑ American Express ❑ Discover/Novus

Account Number: Expiration Date:

Billing Address: **Phone:**
City: **State:** **Zip Code:**
Card Holder's Name: **Signature:**

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Application for SB 306 Extension / Delay in Compliance

D	Name of Facility (from front page):	OSHPD #
E	Enclosed with this application are the following documents: ❑ **Extension Request**	

❑ **Declaration of Intent form**
Date Sent : _____

❑ **Supplemental information required to be submitted as part of the Declaration of Intent form**
Date Sent: _____

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INSTRUCTIONS
Application for SB 306
Extension / Delay in Compliance
(OSH-FDD-400)

Do not write in Office Use Only area on this application.

A Enter name as it appears on the facility license. Enter email address, street address, city, county, zip code, phone number, and fax number.

Enter the name of the Facility Representative/Administrator, email address, phone number, fax number, city, state, and zip code. Copies of all correspondence will be sent to the Facility Representative/Administrator. If no Facility Representative/Administrator address is entered, copies of all correspondence will be sent to the Facility address as indicated on the license to the attention of Facility Administrator.

Enter name, phone number, mailing address, city, state and zip code of the Legal Owner.

B The "Application for SB 306 Extension/Delay in Compliance" is to be signed by the legal owner, administrator of the facility, or authorized agent. Indicate in the appropriate boxes the name, signature, title, address, city, state, zip code, phone number and fax number and of the applicant.

C Fee - The fee for submittal for an extension/delay in compliance under SB 306 is $1,000.00 (nonrefundable). All fees and reports shall be submitted by the applicant to OSHPD's Facilities Development Division at the following address:

Office of Statewide Health Planning & Development
Healthcare Information Division - Healthcare Information Resource Center
400 R St, Room 250 ~ Sacramento, California 95811

D Enter the name of the facility from Section A on Page 1.

E Indicate the documents enclosed on application form.

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Hospital Declaration of Intent

_____ (Legal Owner / Administrator or Agent for the Legal Owner / Administrator) hereby declares to the Office of Statewide Health Planning and Development (OSHPD) our intent to apply for relief under the provisions of Health and Safety Code §130061.5.

Please attach to this declaration a report providing the following information:

1. Hospital Name(s)
2. OSHPD Facility Number(s)
3. License number(s)
4. Structures currently listed on SPC-1 list.
5. Statement regarding the buildings use for direct patient care.
6. The hospital owner has requested an extension of the deadline described in Health and Safety Code, subdivision (a) or (b) of Section 130060.
7. Hospital has submitted demonstration that it is owned or operated by a city, county or city and county (if so, please skip steps 8-11 below).
8. Hospital has submitted financial information to OSHPD by July 1, 2007 for the most recent fiscal year prior to that date showing the following, for the hospital owners and all of its hospital affiliates, considered in total:
    a. Net long-term debt to capitalization > 60%.
    b. Debt service coverage < 4.5
    c. Cash to debt ratio < 90%
9. Hospital maintains a contract with the California Medical Assistance Commission (CMAC) under the selective provider contracting program (unless in an open area established by CMAC).
10. Hospital continues to maintain at least basic Emergency Medical Services, if the hospital provided emergency medical services at the basic or higher level as of 7/1/2007.
11. Hospital meets at least one of the following criteria:
    a. The hospital is located within a Medically Underserved Area or a Health Professions Shortage Area designated by the federal government pursuant to Sections 330 and 332 of the federal Public Health Service Act (42 U.S.C. Secs. 254b and 254e).
    b. The CMAC determines that the hospital is essential to providing and maintaining Medi-Cal services in the hospital's service area.
    c. The hospital demonstrates that, based on annual utilization data submitted to the office for 2006 or later, the hospital had in one year over 30 percent of all discharges for either Medi-Cal or indigent patients in the county in which the hospital is located.
    d. If the one of the above is not met:
        i. OSHPD will determine, by means of a health impact assessment, that removal of the building or buildings from service may diminish significantly the availability or accessibility of health care services to an underserved community.

Signed (Legal Owner / Administrator or Agent) Date